

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

09477

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09477

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) District of Columbia DISTRICT OF COLUMBIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stump Neck		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 3926-Wheeler Road	
3. NAME OF DECEASED (Type or print) John Henry Bean Jr.		4. DATE OF DEATH 7-16-67	
5. SEX Male	6. COLOR OR RACE N Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-34
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy-Enlisted		10b. KIND OF BUSINESS OR INDUSTRY US-Navy	9. AGE (In years lost birthday) yrs. 33
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Bean Sr		14. MOTHER'S MAIDEN NAME Sadie Agnes Stubbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Still in at time of death		16. SOCIAL SECURITY NO. 578-46-8577	
17. INFORMANT Navy Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatal Submersion DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 929.4			INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On a picnic at Stump Neck. Was swimming in a pond when he suddenly sank. Body recovered about 30 min. later.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7 p.m. 7-16- 19 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Recreation Center	20f. (City or town) (County) (State) Charles Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James E. Andrews		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Indian Head Md Charles County	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-21-67	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Falls Church Funeral Home		25a. REC'D BY REGISTRAR JUL 24 1967	
1102 West Broad Street, Falls Church, Virginia		25b. REGISTRAR'S SIGNATURE J Charles Judge	

1000 West Broad Street, Richmond, Virginia
Jul 1 1961
Atlantic National Cemetery, Virginia

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FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09478

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b Nanjemoy	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians General Hospital		d. STREET ADDRESS Nanjemoy, Maryland	
3. NAME OF DECEASED (Type or print) Smith Emory Bowie		4. DATE OF DEATH Month July Day 13 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Charles County, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph E. Bowie		14. MOTHER'S MAIDEN NAME Edith M. Maddox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-24-899	
17. INFORMANT Harry B. Bowie, Nanjemoy, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive left hemothorax DUE TO (b) Perforation of left lung and aorta DUE TO (c) lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject shot in chest	
20c. TIME OF INJURY Month, Day, Year 10:15 p.m. 7 13 19 67	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) His store	20f. (City or town) (County) (State) Nanjemoy Charles Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED July 14, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 17, 1967	
23c. NAME OF CEMETERY OR CREMATORY Nanjemoy, Baptist		23d. LOCATION (City or Town) (County) (State) Nanjemoy, Charles, Md.	
24. FUNERAL DIRECTOR Arehart Funeral Home Inc., La Plata, Md.		25a. REC'D BY REGISTRAR JUL 21 1967	
25b. REGISTRAR'S SIGNATURE Johnas Judge			

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09479

CERTIFICATE OF DEATH

09479

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville, 08-1	
c. LENGTH OF STAY IN lb 3 yrs		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Oscar Penn Bridgett		4. DATE OF DEATH Month Day Year July 17, 1967	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1875 92 yrs.
9. AGE (In years last birthday) 92		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tobacco	
11. BIRTHPLACE (County & State, or foreign country) Charles Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Thomas Bridgett		14. MOTHER'S MAIDEN NAME Lucrecia Dent	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-36-5776	
17. INFORMANT Adrian Bridgett, Hughesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Atherosclerosis of coronary arteries DUE TO (c) 15 yrs		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, public bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to July 17 , 19 67 , that (I) (we) lost saw the deceased alive on July 13 , 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE J. Roy Guyther		22b. DATE SIGNED 7-18-67	
22c. PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.		22d. ADDRESS Mechanicsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-20-67	
23c. NAME OF CEMETERY OR CREMATORY Trinity Ch. Cemetery		23d. LOCATION (City or Town) (County) (State) Newport, Charles, Md.	
24. FUNERAL DIRECTOR Huntt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR JUL 21 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

REPORT OF AGENT

20472

Special Agent

Assigned

Assigned

Residence

Age

Occupation

Date of Birth: 10-10-03
Place of Birth: [illegible]
Education: [illegible]
Marital Status: [illegible]

Character of Work: [illegible]

Employment History: [illegible]
Previous Employers: [illegible]

References: [illegible]

Remarks: [illegible]

Date of Report: 10-10-03
Agent's Signature: [illegible]
Special Agent in Charge: [illegible]

FOR STATE
HEALTH DEPT.

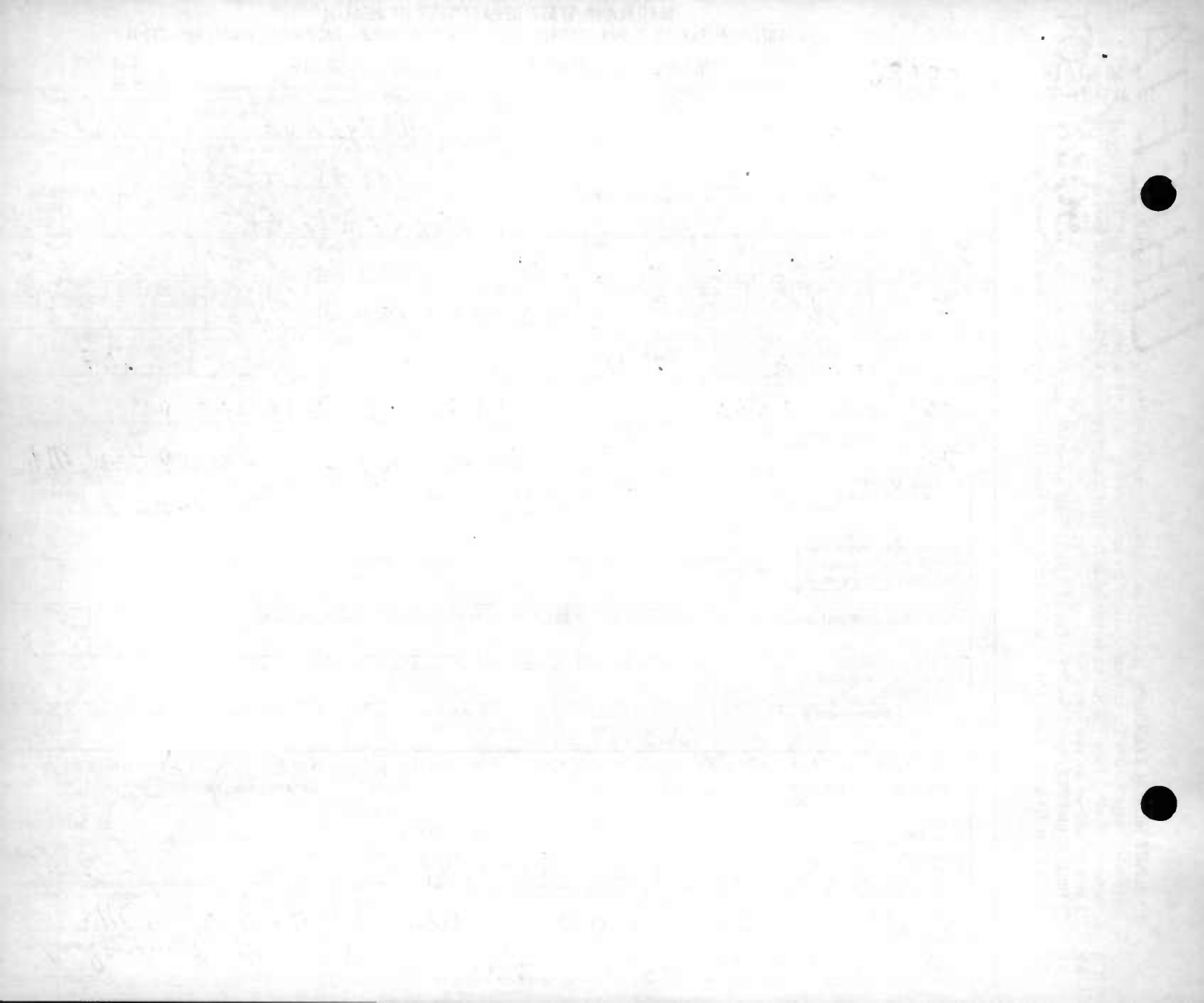
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09480		09480	
1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) INDIAN HEAD	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) INDIAN HEAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 154 CIRCLE AVE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last SALLIE H. BYRD		4. DATE OF DEATH Month Day Year 7 2 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 15 1888
9. AGE (In years lost birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home work		10b. KIND OF BUSINESS OR INDUSTRY Dom	11. BIRTHPLACE (State or foreign country) VA.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SAM WALL	
14. MOTHER'S MAIDEN NAME NANNIE DUNNINGTON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) W	
16. SOCIAL SECURITY NO.		17. INFORMANT CHARLES H. BYRD Address INDIAN HEAD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED 7-2-67		23. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
24. ACTUAL SIGNATURE EXAMINER'S NAME (Type) E. S. EdeLEN, LA PLATA MD.		25. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
26a. BURIAL, CREMATION, REMOVAL (Specify) Burial		26b. DATE THEREOF 7-5-67	
26c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL		26d. LOCATION (City or Town) (County) (State) WALDORF MD	
27. FUNERAL DIRECTOR Smith Funeral Home		28. ADDRESS Waldorf Md	
29. REC'D BY REGISTRAR DATE JUL 6 1967		30. REGISTRAR'S SIGNATURE Charles J. J...	



CERTIFICATE OF DEATH

09481

09481

1. PLACE OF DEATH a. COUNTY CHARLES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY CHARLES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) White Plains	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial Hospital		d. STREET ADDRESS Box 16	
3. NAME OF DECEASED (Type or print) HORACE LINWOOD COLLINS		4. DATE OF DEATH 7 15 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Agent		10b. KIND OF BUSINESS OR INDUSTRY Penn. R.R.	11. BIRTHPLACE (County & State, or foreign country) Delaware
13. FATHER'S NAME Jacob Collins		14. MOTHER'S MAIDEN NAME Laura ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-07-7858	
17. INFORMANT Mrs Jennie M. Collins, White Plains, Md.		Address Box 16	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accidental See Aut Sec DUE TO (b) 331X DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-12-67 to 7-15-67 ; that (I) (we) last saw the deceased alive on 7-15-67 , and that death occurred at 7-15-67 M, from the causes and on the date stated above.			
22a. SIGNATURE E. J. EDENHARDT		22b. DATE SIGNED 7-15-67	
22c. PHYSICIAN'S NAME (Type) E. J. EDENHARDT M.D.		22d. ADDRESS La Plata Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Osborn Family Cemetery	23d. LOCATION (City, town or county) (State) Waldorf, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home Inc., La Plata, Md.		25a. REC'D BY REGISTRAR JUL 21 1967	
		25b. REGISTRAR'S SIGNATURE Charles Jones	

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STATE OF TEXAS

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09482 CERTIFICATE OF DEATH 09482

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u> d. STREET ADDRESS <u>13 Gabriel Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Loretta Michelle Comeau</u> First Middle Last		4. DATE OF DEATH <u>July 24</u> 19 <u>67</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1961</u> 9. AGE (In years last birthday) <u>6</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Louis Edward Comeau</u>		14. MOTHER'S MARDEN NAME <u>Laura Vanwart</u>	
15. WAS DECEASED EVER IN U.S. ARMOE FORCES? (Yes, no, or unknown) <u>-</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Louis E. Comeau</u> Address <u>Bryans Road, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 1934 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Neuroblastoma</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>19 MO.</u>			
PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>65</u> , to <u>7/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/23</u> 19 <u>67</u> , and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas L. Fieldson</u> M.D.		22b. DATE SIGNED <u>7/23/67</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS L. Fieldson M.D.</u>		22d. ADDRESS <u>BRANDYWINE, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-27-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>The Hunt Funeral Home, Wallingford, Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>JUL 31 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

3822

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09483

CERTIFICATE OF DEATH

09483

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN lb 18 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Issue d. STREET ADDRESS Issue e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY G. DONLEY				4. DATE OF DEATH July 28 1967			
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-26-90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES BURRGOUGHS				14. MOTHER'S MAIDEN NAME JULLA SWANN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-30-4978A		17. INFORMANT Mrs. Ethel Butler-Daughter-Issue, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Diabetes Mellitus DUE TO (c) Carcinoma of the Sigmoid INTERVAL BETWEEN ONSET AND DEATH 1 week 10 years 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-20 , 19 67 to 7-28 , 19 67 , that (I) (we) last saw the deceased alive on 7-28 , 19 67 , and that death occurred at 9A M, from causes and on the date stated above.							
22a. SIGNATURE F.M. JOHNSON MD				22b. DATE SIGNED 7-28-67		22c. PHYSICIAN'S NAME (Type) F.M. JOHNSON MD	
22d. ADDRESS LA PLATA, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/31/1967		23c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery		23d. LOCATION (City or Town) (County) (State) Issue, Maryland	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.				25a. REC'D BY REGISTRAR AUG 1 1967		25b. REGISTRAR'S SIGNATURE Charles Jones	

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CENTRAL OF NORTH

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CAROLINE

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CERTIFICATE OF DEATH

09484

09484

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN lb <u>Bryantown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial Hosp.</u>		d. STREET ADDRESS <u>Edelen Road</u>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>G.</u> Middle <u>Edelen</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Caw.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25 1880</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bryantown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Benjamin M. Edelen</u>	
14. MOTHER'S MAIDEN NAME <u>Mary T. Gardiner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>577-16-2285</u>		17. INFORMANT <u>Edelen B. Edelen</u> Address <u>Bryantown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 Congestive heart failure</u> DUE TO (b) <u>subhigh arteriosclerosis</u> DUE TO (c) <u>last.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>kidney failure</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> , 19 <u>67</u> , to <u>7/28</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>7/28</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>Arturo M. Monteiro</u>		22b. DATE SIGNED <u>7/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arturo M. Monteiro</u>		22d. ADDRESS <u>La Plata, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 31, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	23d. LOCATION (City or town) (County) (State) <u>Bryantown Chas. Md.</u>
24. FUNERAL DIRECTOR <u>The Hunt Funeral Home, Walkersville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECORD OF DEATH

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FEB 10 1900



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09485

CERTIFICATE OF DEATH

09485

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CHARLES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN lb 08/1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physician Memorial Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) U A N First Middle Last S. HANCOCK		4. DATE OF DEATH Month Day Year JULY 13 1967			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1882	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Charles County, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Hancock		14. MOTHER'S MAIDEN NAME Sarah Bradshaw	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Gerald Hancock-son- Nanjemoy, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular occlusion 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 9 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-3 , 19 67 to 7-13 , 19 67 that (I) (we) last saw the deceased alive on 7-13 , 19 67 , and that death occurred at 21 M, from causes and on the date stated above.					
22a. SIGNATURE F. M. JOHANSON		22b. DATE SIGNED 7-13-67		22c. PHYSICIAN'S NAME (Type) F. M. JOHANSON	
22d. ADDRESS LA PLATA, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 16, 1967	23c. NAME OF CEMETERY OR CREMATORY Nanjemoy Baptist	23d. LOCATION (City or Town) (County) (State) Nanjemoy, Charles, Md.		
24. FUNERAL DIRECTOR Arehart Funeral Home Inc., La Plata, Md.		25a. REC'D BY REGISTRAR DATE JUL 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

RECEIVED
JUNE 19 1964

MINISTRY OF DEFENSE

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SECRET

SECRET

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09486		09486	
1. PLACE OF DEATH o. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf d. STREET ADDRESS P. O. Box 264 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl Hill		4. DATE OF DEATH Month Day Year July 24, 1967	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/67
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months Days Hours Min. 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles Washington		14. MOTHER'S MAIDEN NAME Dorrie Octavia Hill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None.	
17. INFORMANT Mother		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7615 IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/24 , 19 67 , to 7/24 , 19 67 , that (I) (we) last saw the deceased alive on 7/24 , 19 67 , and that death occurred at 7:30 M, from causes and on the date stated above.			
22a. SIGNATURE Arturo M. Monteiro		22b. DATE SIGNED 7/24/67	
22c. PHYSICIAN'S NAME (Type) Arturo M. Monteiro M.D.		22d. ADDRESS La Plata, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 7-26-67	23c. NAME OF CEMETERY OR CREMATORY St. Peter's	23d. LOCATION (City or Town) (County) (State) Waldorf close Md
24. FUNERAL DIRECTOR Beckhart Inc La Plata Md		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09487

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Ches</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spadon</u>		c. LENGTH OF STAY IN 1b <u>5 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>214 Lralia Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES EDWARD HUBBERT</u>		4. DATE OF DEATH <u>7</u> Month <u>13</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-15</u> 9. AGE (In years, months, & days) <u>52</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADJUSTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALVIN C. HUBBERT</u>		14. MOTHER'S MAIDEN NAME <u>MARY BURGRAF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>MRS. JEANNE C. HUBBERT</u>		Address <u>SEE # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>Coronary Heart</u> DUE TO <u>Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Myocardial infarction</u> DUE TO <u>Myocardial infarction</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>7-11-1967</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Spadon</u> (County) <u>Ches</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. E. DeLena</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. E. DELENA MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>214 Lralia Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7/16/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>	23d. LOCATION (City or Town) <u>SALISBURY WICO. MD</u> (County) <u>Wico</u> (State) <u>Md</u>
24. FUNERAL DIRECTOR <u>The Hunt General Home, Waldorf, Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>JUL 18 1967</u> DATE	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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ADJUSTED TO SHOW
ALAN C. HUBERT
YES, WITH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

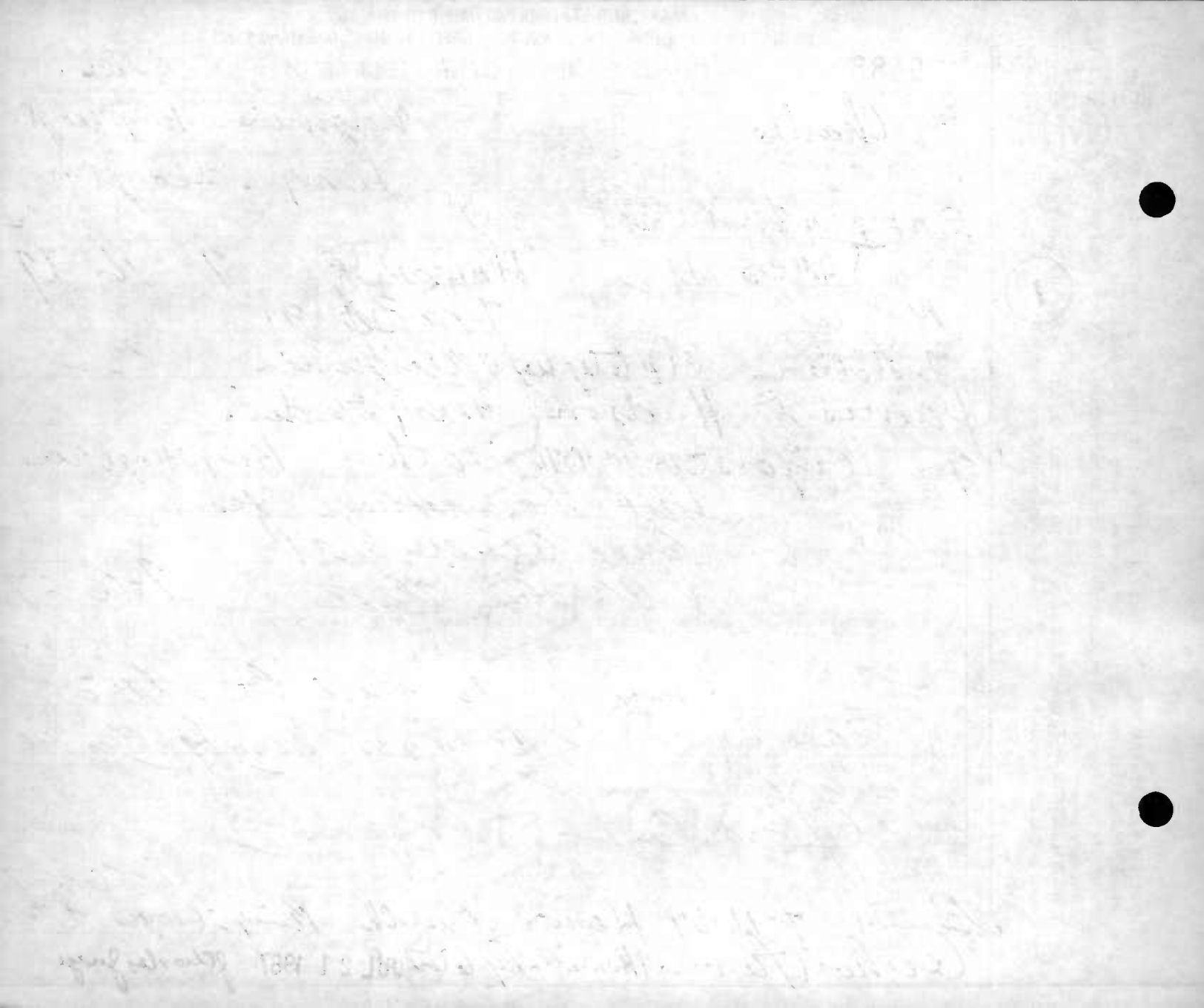
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09488

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09488

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>King George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Do Agby Memorial Hospit</u>		d. STREET ADDRESS <u>King George 833</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES D HUDSON JR</u>		4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-36</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Installer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cable telephone</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James D Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mardenis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or codes of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>039-44-1576</u>	
17. INFORMANT <u>Father</u>		Address <u>King George Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>from newspaper from</u> (c) <u>Guac Skull and</u> <u>Crushed Chest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7-16-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto which hit a tree</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> Min <u>16</u> p.m. <u>1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 20</u>	20f. (City or town) <u>King George</u> (County) <u>King George</u> (State) <u>VA</u>
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>[Signature]</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>King George 833</u>	
22. DATE SIGNED <u>7-16-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harold Church</u>	23d. LOCATION (City or Town) (County) (State) <u>King George VA</u>
24. FUNERAL DIRECTOR <u>Cerhart Funeral Home & Supply</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



CERTIFICATE OF DEATH

09489

09489

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE - MARYLAND b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Mem. Hosp				d. STREET ADDRESS 215 GARNER AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES J. MORRELL				4. DATE OF DEATH Month JULY Day 2 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH NOV. 4 1893		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Post Office		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV		11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY U.S.A	
13. FATHER'S NAME CHARLES MORRELL				14. MOTHER'S MAIDEN NAME ANN Zimmerman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO. 077-30-2038		17. INFORMANT Ruth B. Morrell		Address 215 GARNER AVE WALDORF, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) COR PULMONALE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 years 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-24 , 19 67 to 7-2 , 19 67 , that (I) (we) last saw the deceased alive on 7-1 , 19 67 , and that death occurred at 8:45 M, from causes and on the date stated above.							
22a. SIGNATURE F. M. JOHANSON				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-2-67	
22c. PHYSICIAN'S NAME (Type) F. M. JOHANSON				22d. ADDRESS LA PLATA, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUL 5 1967		23c. NAME OF CEMETERY OR CREMATORY LONG ISLAND NAT CEM		23d. LOCATION (City or Town) (County) (State) NEW YORK N.Y.	
24. FUNERAL DIRECTOR HUNT FUNERAL HOME				ADDRESS WALDORF MD		25a. REC'D BY REGISTRAR JUL 5 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

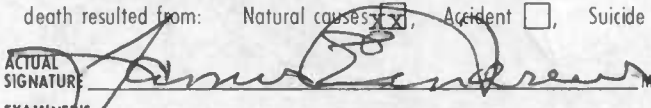

MARYLAND STATE DEPARTMENT OF HEALTH

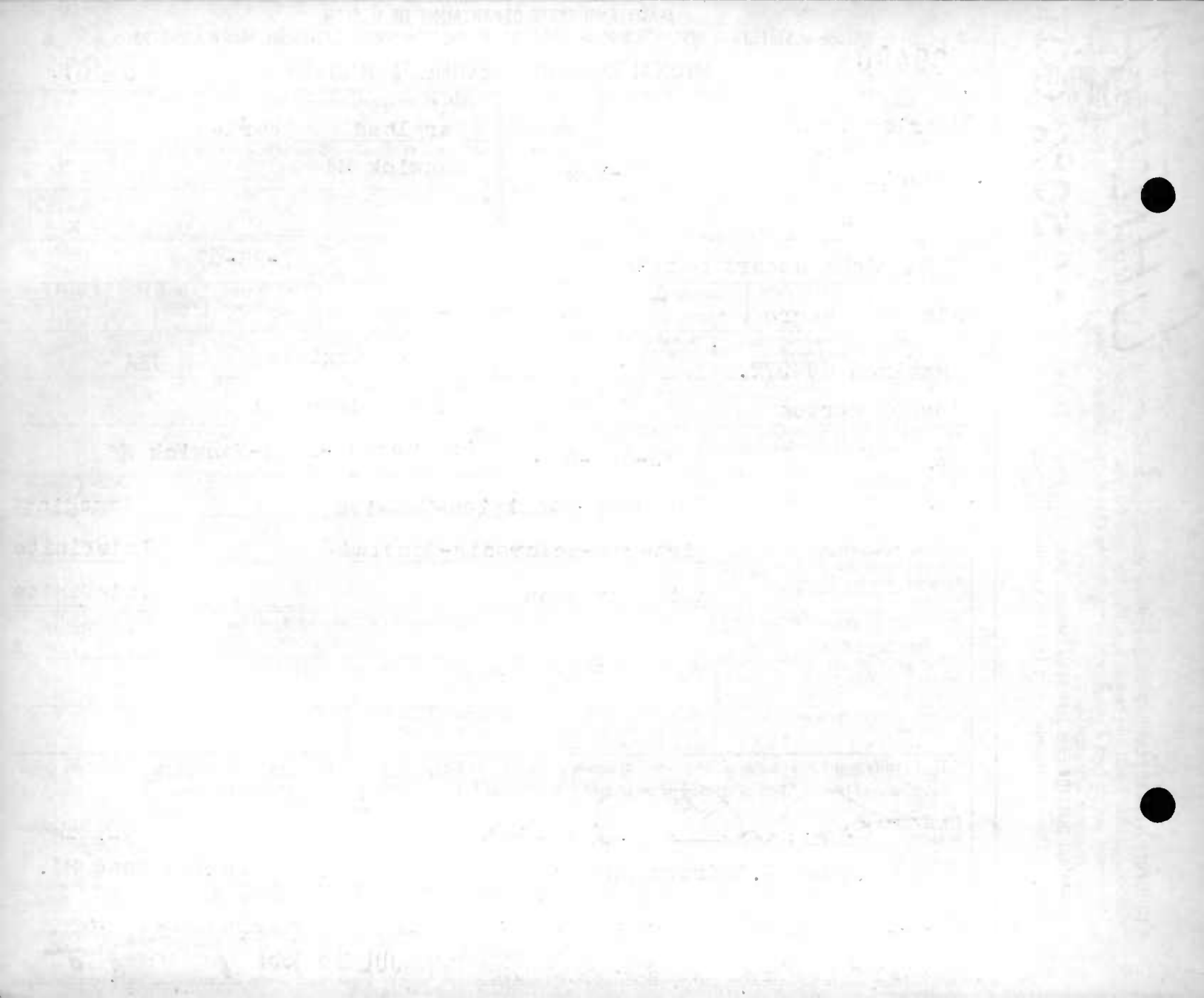
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09490

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09490

1. PLACE OF DEATH a. COUNTY Charles County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fenwick Md		c. LENGTH OF STAY IN 1b 36-Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Robert Morton First Middle Last		4. DATE OF DEATH 7-25-67 Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2025-1889
9. AGE (In years last birthday) yrs. 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired USGOVT.	11. BIRTHPLACE (State or foreign country) Brooke Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Morton	
14. MOTHER'S MAIDEN NAME Hannah Campbell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 76-425-859		17. INFORMANT Eliza Morton-Wife-Fenwick Md Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Occlusion-Massive DUE TO (b) Arterio-Sclerosis-General DUE TO (c) Aging process		INTERVAL BETWEEN ONSET AND DEATH Immediate Indefinite Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspections <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE:  EXAMINER'S NAME (Type) James E. Andrews MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Indian Head Md.	
22. DATE SIGNED 7-25-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-28-67	23c. NAME OF CEMETERY OR CREMATORY MALEDONIA BAPT. CHURCH	23d. LOCATION (City or Town) (County) (State) BRYANS ROAD MD.
24. FUNERAL DIRECTOR BARNES & MATTHEWS, INC. 3619-14 ST. N.W.		25a. REC'D BY REGISTRAR DATE JUL 28 1967	
25b. REGISTRAR'S SIGNATURE 			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09491

CERTIFICATE OF DEATH

09491

1. PLACE OF DEATH o. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b Cobb Island	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicans Memorial Hospital		d. STREET ADDRESS 181	
3. NAME OF DECEASED (Type or print) First ETHEL Middle CLARA Last PENN		4. DATE OF DEATH Month JULY Day 27 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1918
9. AGE (In years last birthday) 49		10. IF UNDER 1 YEAR Months 49 Days 27 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold Beyer		14. MOTHER'S MAIDEN NAME Ethel (Unkown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. William Earl Penn-Cobb Island, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) WATER HOUSE - FRIEDRICHSEN SYNDROME 0571 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Renal infection DUE TO (c) 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-25, 1967 to 7-27, 1967 , that (I) (we) last saw the deceased alive on 7-27, 1967 , and that death occurred at 3 A.M. from causes and on the date stated above.			
22a. SIGNATURE F.M. Johnson MD		22b. DATE SIGNED 7-27-67	
22c. PHYSICIAN'S NAME (Type) F.M. JOHNSON MD		22d. ADDRESS La Plata, Md, 20646	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/29/1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. La Plata, Md.		25a. REC'D BY REGISTRAR AUG 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5230

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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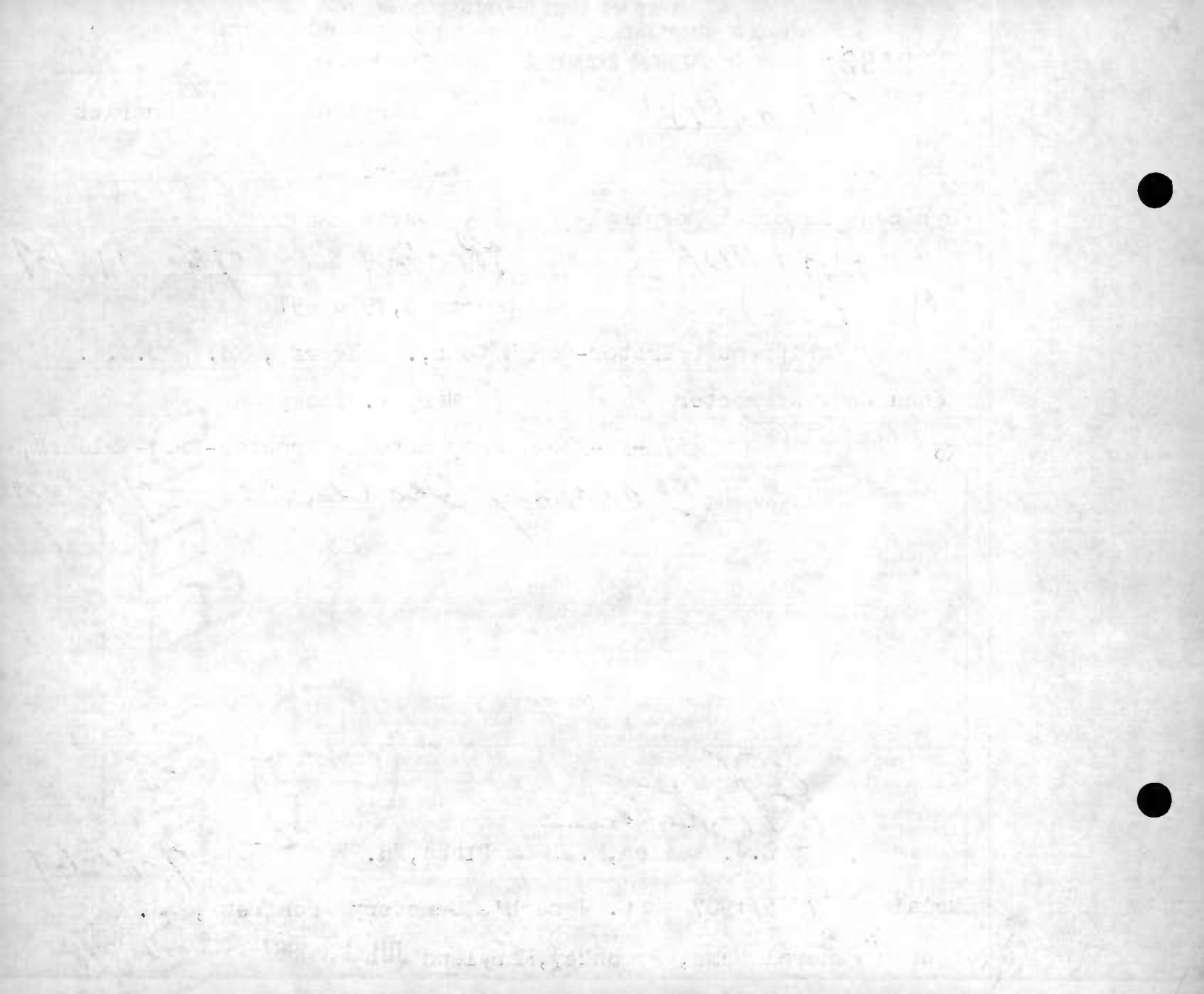
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09492

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09492

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN lb <u>Waldorf</u> 08.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicans Memorial Hospital</u>		d. STREET ADDRESS <u>Davis Road</u>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>ARTHUR PROCTOR</u>		4. DATE OF DEATH Month <u>7th</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1916</u>
9. AGE (In years last birthday) <u>51</u>		9. AGE (In years last birthday) <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heavy Equipment Operator-Gough</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cons.,. Waldorf, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Andrew Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-34-9281</u>	
17. INFORMANT <u>Mary Estelle Proctor-Wife-Waldorf, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>INTERVAL BETWEEN ONSET AND DEATH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>7-11-67</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E.J. Edelen</u> M.D.		22. DATE SIGNED <u>7-11-67</u>	
EXAMINER'S NAME (Type) <u>E.J. Edelen, M.D. La Plata, Md.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/15/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pomfret, Md.</u>
24. FUNERAL DIRECTOR <u>Johnson Funeral Home, Pomonkey, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT

09493

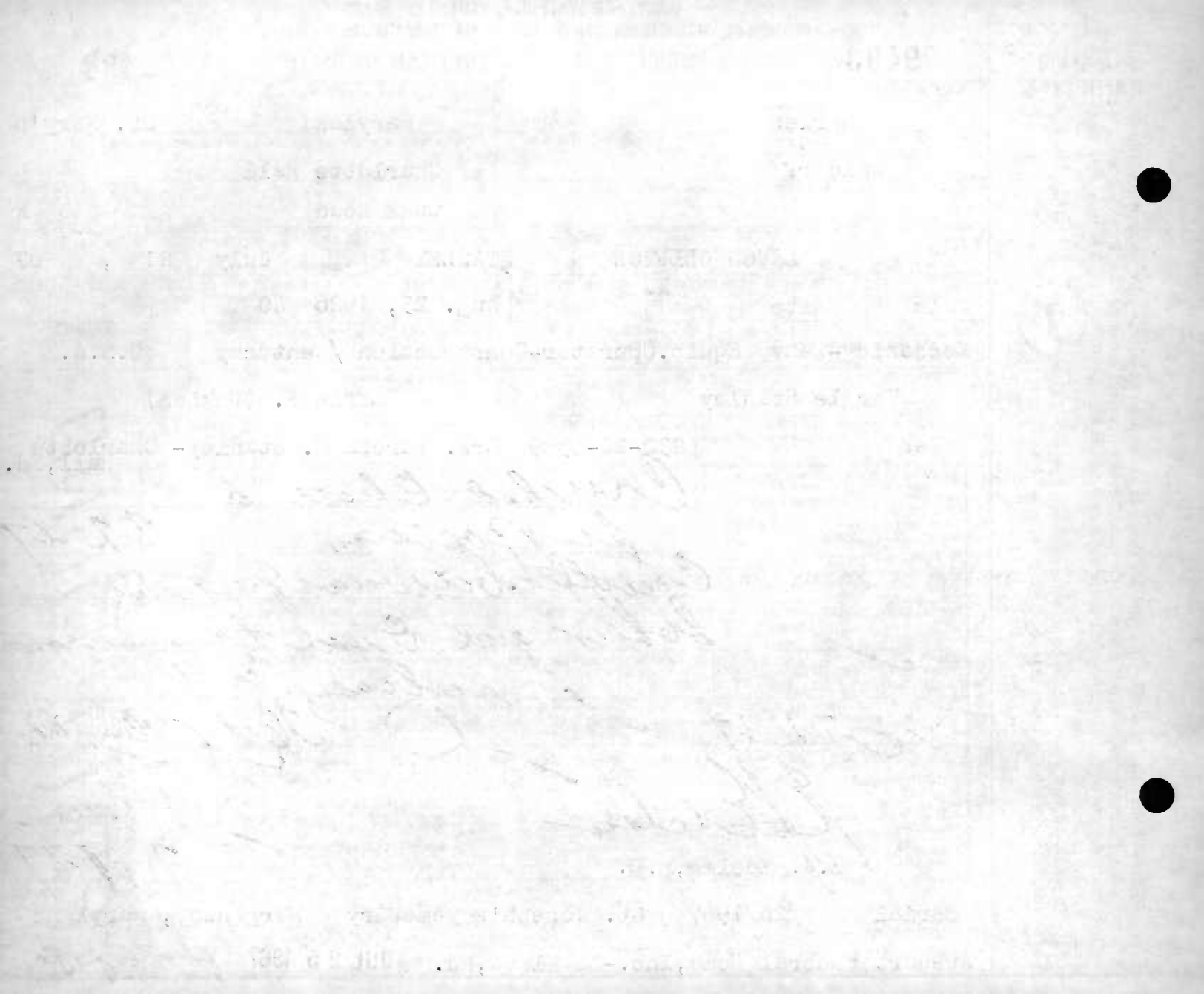
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09493

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

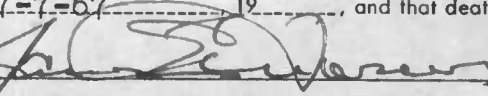
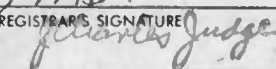
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN lb Charlotte Hall	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Oaks Road	
3. NAME OF DECEASED (Type or print) LAVON CLIFTON STANLEY		4. DATE OF DEATH Month July Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1926
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic - heavy Equip. Operator		9. AGE (In years last birthday) yrs. 40	
10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Vergle Stanley	
14. MOTHER'S MAIDEN NAME Effie F. (Unkown)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes	
16. SOCIAL SECURITY NO. 230-20-4329		17. INFORMANT Mrs. Teresa M. Stanley- Charlotte Hall, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Crushed Chest & suffocation 9123 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Caught between front end of car and rigid transmission (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Robber and Rigged Transmission		INTERVAL BETWEEN ONSET AND DEATH 7-21-67	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) in loading	
20c. TIME OF INJURY Month, Day, Year 7-21-67 Hour a.m. 7 p.m. 11		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Needy Club Me		20f. (City or town) (County) (State) Needy Club Me	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 7-21-67	
ACTUAL SIGNATURE E. J. Edelen		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. Edelen, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/26/1967	
23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d. LOCATION (City or Town) (County) (State) Morganza, Maryland	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		25a. REC'D BY REGISTRAR JUL 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md c. LENGTH OF STAY IN 1b 26 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md d. STREET ADDRESS 34-Cypress Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Zada Armatha Talbott First Middle Last		4. DATE OF DEATH 7-7-67 Month Day Year	
5. SEX Female	6. COLOR OR RACE W-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-1913 9. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William E. Giffen	
14. MOTHER'S MAIDEN NAME Sylvia Byrne		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 213-40-7813		17. INFORMANT Husband-Sherman Talbott Address 34-Cypress Place Indian Head Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion-Massive DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis General DUE TO (c) Obesity		INTERVAL BETWEEN ONSET AND DEATH Immediate Indefinite Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-6-67 , 19____, to 7-7-67 , 19____, that I last saw the deceased alive on 7-7-67 , 19____, and that death occurred at 10-AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Indian Head Md 7-7-67			
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) James E. Andrews MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-11-67	22c. NAME OF CEMETERY OR CREMATORY SAMPLES MANOR Cem.	22d. LOCATION (City, town, or county) (State) DARGEN, MD.
23. FUNERAL DIRECTOR'S SIGNATURE HUNT FUNERAL HOME, WALDORF, MD.		24a. REC'D BY REGISTRAR DATE JUL 12 1967	24b. REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

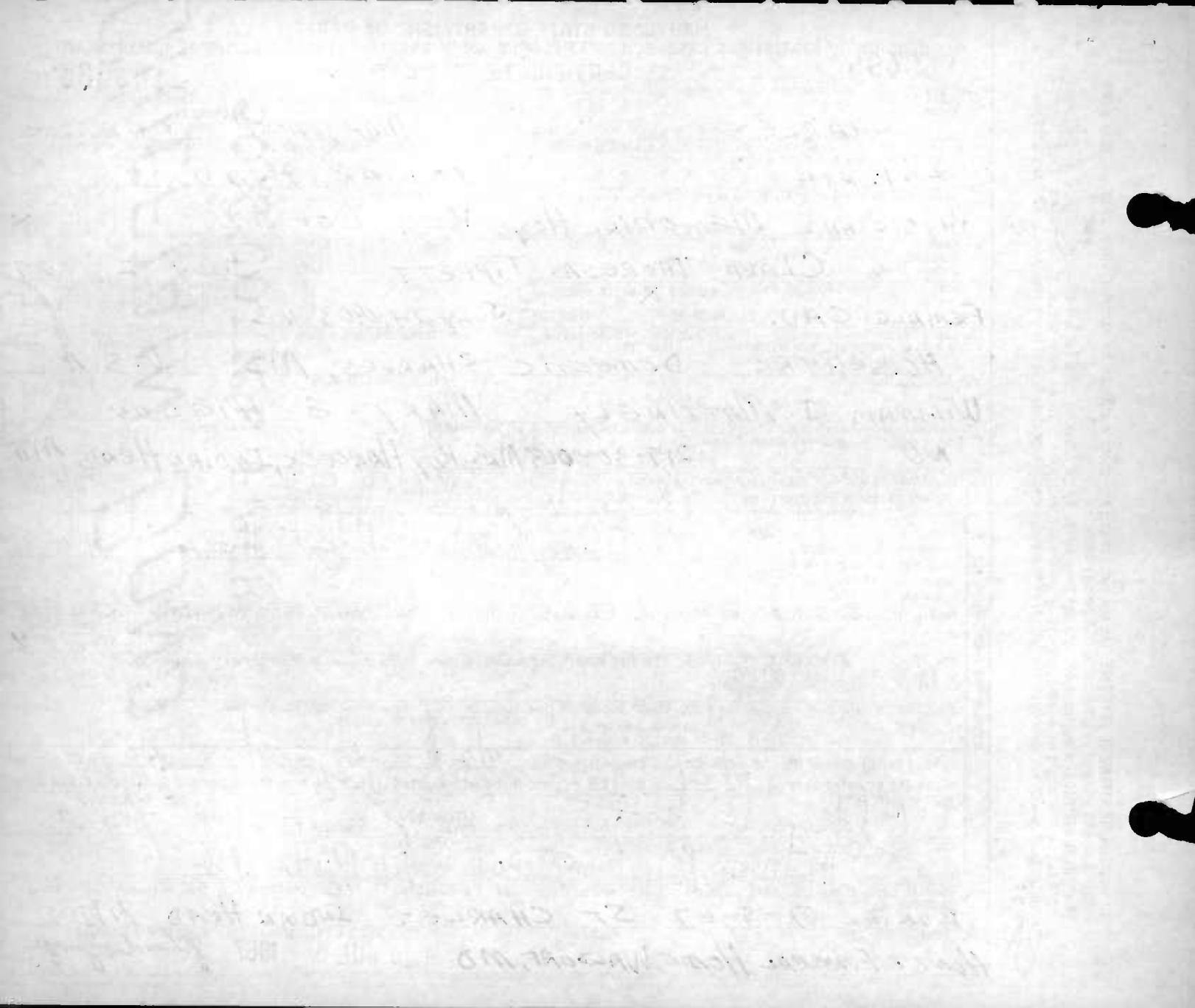
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09495 CERTIFICATE OF DEATH 09495

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) INDIAN HEAD			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial Hosp				d. STREET ADDRESS Rt 1 Box 42			
3. NAME OF DECEASED (Type or print) First Middle Last CLARA THERESA TIPPETT				4. DATE OF DEATH Month Day Year JULY 2, 1967			
5. SEX FEMALE		6. COLOR OR RACE CAU.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 24, 1903	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (County & State, or foreign country) CHARLES MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William J. Mattingly				14. MOTHER'S MAIDEN NAME MARY E. Higdon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 217-30-0068			
17. INFORMANT Mrs. Roy Hancock				Address Indian Head, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/24 , 19 67 to 7/2 , 19 67 , that (I) (we) last saw the deceased alive on 7/24 , 19 67 , and that death occurred at 11:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Arturo M. Monteiro						22b. DATE SIGNED 7/3/67	
22c. PHYSICIAN'S NAME (Type) Arturo M. Monteiro						22d. ADDRESS La Plata, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-5-67		23c. NAME OF CEMETERY OR CREMATORY ST CHARLES		23d. LOCATION (City, town or county) (State) INDIAN HEAD MD	
24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.				25a. REC'D BY REGISTRAR JUL 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Issue	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Issue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Daniel Middle T. Last Veihmeyer		4. DATE OF DEATH Month July Day 11 Year 1967	
5. SEX MALE	6. COLOR OR RACE cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-19-1906
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE		9b. KIND OF BUSINESS OR INDUSTRY RETIRED	9. AGE (In years last birthday) 61 yrs.
10a. FATHER'S NAME DANIEL T. VEIHMAYER		11. BIRTHPLACE (County & State, or foreign country) WASH., D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. MOTHER'S MAIDEN NAME MARY G. FOX	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		15. SOCIAL SECURITY NO. 577-14-0048	
16. INFORMANT EVELYN LEINS		17. ADDRESS 2141 I ST. N.W., WASH., D.C. 20037	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Years			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 10 Jul , 19 62 , to 11 Jul , 19 67 , that (I) (we) last saw the deceased alive on 12 May 19 67 and that death occurred at UNKNOWN , from causes and on the date stated above.			
22a. SIGNATURE J. Barry Mason		22b. DATE SIGNED 12 Jul 67	
22c. PHYSICIAN'S NAME (Type) J. G. BARRY MASON		22d. ADDRESS LA PLATA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-14-67	23c. NAME OF CEMETERY OR CREMATORY CHRIST CH. Cem.	23d. LOCATION (City or Town) (County) (State) WAYSIDE, CHARLES, MD.
24. FUNERAL DIRECTOR HUNTT FUNERAL HOME, WALDORF, MD.		25a. REC'D BY REGISTRAR JUL 17 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

CHAPTER

SECTION

WILEY

BRANCH

VEHICLE

JULY

Unilateral Infection

Orthodontic Carcinoma of the Mouth

General Notes

15 and 16

10 feet

15 feet

15 feet

X

15 feet